

<i>SERFF Tracking Number:</i>	<i>CVKS-128348545</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Coventry Health and Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>APP-ER-05.12</i>		
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001A Any Size Group - PPO</i>
<i>Product Name:</i>	<i>Application for Group Benefits</i>		
<i>Project Name/Number:</i>	<i>/</i>		

## Filing at a Glance

Company: Coventry Health and Life Insurance Company

Product Name: Application for Group Benefits SERFF Tr Num: CVKS-128348545 State: Arkansas

TOI: H16G Group Health - Major Medical SERFF Status: Closed-Approved- State Tr Num:  
Closed

Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: APP-ER-05.12 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Rosalind Minor

Authors: Vanda Johnson, Paula

Bostock, Lisa Foos

Date Submitted: 05/15/2012 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Employer

Filing Status Changed: 05/18/2012

State Status Changed: 05/18/2012

Created By: Vanda Johnson

Corresponding Filing Tracking Number: CVKS-127187464

PPACA: Not PPACA-Related

PPACA Notes: null

Healthcare.gov ID:

Filing Description:

Please find attached for your review and approval an updated Application for Group Benefits, which was previously approved by your office on 6/28/2011 - SERFF CVKS-127187464 - form APP-ER-05.11. A section was added on page 2 for Medical Loss Ratio requirements. On page 3, a statement was also added in regards to the underwriting company and administrator.

Status of Filing in Domicile:

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Vanda Johnson

SERFF Tracking Number: CVKS-128348545 State: Arkansas

Filing Company: Coventry Health and Life Insurance Company State Tracking Number:

Company Tracking Number: APP-ER-05.12

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If you have any questions, please do not hesitate to contact me at 703-794-7755 or Lisa Foos at 316-609-2564.  
Thank you for your attention to this filing.

Sincerely,  
Vanda Johnson  
Policy and Compliance Specialist  
State Narrative:

## Company and Contact

### Filing Contact Information

Lisa Foos, Manager, Regulatory Compliance lfoos@phsystems.com  
8535 E. 21st St. N. 316-609-2564 [Phone]  
Wichita, KS 67206

### Filing Company Information

Coventry Health and Life Insurance Company CoCode: 81973 State of Domicile: Delaware  
8320 Ward Parkway Group Code: 1137 Company Type: LAH  
Kansas City, MO 64114 Group Name: Coventry Health Care State ID Number:  
(866) 795-3995 ext. 4539[Phone] FEIN Number: 75-1296086

## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: \$50/Form  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Coventry Health and Life Insurance Company	\$50.00	05/15/2012	59189673

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/18/2012	05/18/2012

*SERFF Tracking Number:* CVKS-128348545 *State:* Arkansas  
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## **Disposition**

Disposition Date: 05/18/2012

Implementation Date:

Status: Approved-Closed

HHS Status: Not Reported

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Application for Group Benefits	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	APP-ER-05.12	Application/Enrollment Form	Application for Group Initial Benefits				APP-ER-05.12.pdf
05/18/2012							

**Employer Information**

Company Name, including D.B.A:

Federal Tax ID #:

☐ Corporation ☐ Sole Proprietor ☐ Partnership ☐ Other

No. Years in Business

Standard Industry Code (SIC)

Nature of Business:

Corporate Address:

City

State

Zip

Physical Address (if different)

City

State

Zip

Mailing Billing Address (if different)

City

State

Zip

Billing Contact Person

Phone

Fax

Email

Benefits Contact Person

Phone

Fax

Email

Name of Authorized Signatory & Title

Phone

Fax

Email

**Benefits Requested**

Effective Date Requested: \_\_\_\_\_ Products Requested: ☐ Medical ☐ Pharmacy ☐ Dental ☐ Coventry Consumer Choice (C3)

**Medical:** (1) Plan: \_\_\_\_\_ Deductible: \_\_\_\_\_ Copay: \_\_\_\_\_ Coinsurance: \_\_\_\_\_ OOPM: \_\_\_\_\_

(2) Plan: \_\_\_\_\_ Deductible: \_\_\_\_\_ Copay: \_\_\_\_\_ Coinsurance: \_\_\_\_\_ OOPM: \_\_\_\_\_

(3) Plan: \_\_\_\_\_ Deductible: \_\_\_\_\_ Copay: \_\_\_\_\_ Coinsurance: \_\_\_\_\_ OOPM: \_\_\_\_\_

Deductible Accumulates on a ☐ Calendar Year basis or ☐ Contract/Plan Year basis or ☐ Other: \_\_\_\_\_

**Pharmacy:** ☐ QHDHP ☐ Super Joe **OR** ☐ Tier 1: \_\_\_\_\_ Tier 2: \_\_\_\_\_ Tier 3: \_\_\_\_\_ Tier 4: \_\_\_\_\_ ; Mail Order: ☐ x 1 ½ ☐ x 2 ☐ x 2 ½ ☐ x 3

Deductible Applies to: ☐ All Tiers **OR** **ONLY** to Tier: ☐ 1 ☐ 2 ☐ 3 ☐ 4 Deductible Amount: \_\_\_\_\_

**Dental:** Plan Name: \_\_\_\_\_ Plan Code: \_\_\_\_\_ Rates: EE: \_\_\_\_\_ EE+SP \_\_\_\_\_ EE+CH \_\_\_\_\_ F: \_\_\_\_\_

\* Employer must contribute at least 50% of employee premium. For contribution amounts less than 50%, the rates will be increased to voluntary levels.

**Coventry Consumer Choice (C3):** ☐ FSA (☐ Medical ☐ Dependent Care) ☐ HSA ☐ HRA ☐ POP

**Contract Information**

Coverage Begins

☐ First of month following:

☐ Date of Hire ☐ 30 days ☐ 60 days ☐ 90 days

Coverage Terminates

☐ End of Month

☐ Date of Termination

Employee Class Covered

☐ Full-time\* ☐ Part-time

\* Statutory minimums required.

☐ Date of Hire

Retirees Covered

☐ No

☐ If Yes, Are they Covered?

☐ Under age 65

☐ Age 65 & older

☐ Dependents of Retirees

Other Eligibility criteria, not listed above

Billing Options:

- ☐ Separate bill by Class  
☐ Combined bill  
☐ Separate bill by location

Do any employees, to be covered under this Plan, live and work in these areas?

- ☐ Texas  
☐ Oklahoma  
☐ KC Metro – KS  
☐ KC Metro – MO  
☐ Wichita/Hutchinson

### Contribution

### Contribution Percentage

Class Description	Waiting Period (if different than above)	Employee	Dependent
Class I:			
Class II:			
Class III:			

### Enrollment Information

Total number of employees during the proceeding Calendar Year:

Full-time\* employees: \_\_\_\_\_ Part-time: \_\_\_\_\_ Seasonal: \_\_\_\_\_ Union: \_\_\_\_\_

\* Statutory minimums required.

Average number of Employees during the proceeding Calendar Year: \_\_\_\_\_

(Employee means any person employed by the employer, whether or not such person is full-time, part-time, seasonal, and regardless of whether such person is eligible to enroll in the group coverage. For purposes of the minimum MLR requirements, employees are measured as employed on average on business days during the preceding calendar year.) See example below:

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total	Average
FT Emp.	20	22	23	24	25	27	25	22	23	21	20	18	270	
PT Emp.	2	2	2	2	3	3	2	2	1	3	3	3	28	
Seasonal	1	1	1	0	0	0	0	0	0	30	40	40	119	
<b>Total</b>	<b>23</b>	<b>25</b>	<b>26</b>	<b>26</b>	<b>28</b>	<b>30</b>	<b>27</b>	<b>24</b>	<b>24</b>	<b>54</b>	<b>63</b>	<b>61</b>	<b>411</b>	<b>34</b>

Medical Loss Ratio Classification. Check the appropriate box below. More information can be found at [www.hhs.gov](http://www.hhs.gov).

☐ ERISA ☐ Government ☐ Non-ERISA

☐ I agree to distribute any rebates that I receive according to XX Guidelines

☐ I prefer for the Health Plan to distribute any rebates on my behalf.

Total employees eligible	Number electing Coverage	Number employees terminated in last twelve (12) months?
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Waiting periods **WILL** / **WILL NOT** be waived at enrollment for full-time employees\*?

(\* Statutory minimums required.)

Is the employer required to provide COBRA?	Total number of COBRA or State Continuation Participants
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List all Employees/Dependents on Continuation Leave. Include effective date and anticipated end date of Continuation Coverage.

Medicare Secondary Payer Rules (add part-time and full-employees; part-time employees count as a full-time employee)

Did the employer average at least 20 total employees last calendar year? ☐ Yes ☐ No

Did the employer average at least 100 total employees last calendar year? ☐ Yes ☐ No

In the past 36 months, has the Company or any affiliated entity filed for protection or operate under federal/state bankruptcy laws? ☐ Yes\* ☐ No

In the past 36 months, has any creditor filed or threatened to file a petition requesting the Company or any affiliate to be put into bankruptcy? ☐ Yes\* ☐ No

\*If yes, please provide details:

Are all employees, including owners, covered by Worker's Compensation? ☐ Yes ☐ No If no, list employees not covered and indicate why.

List previous group health carriers for past five years. Include type of coverage (PPO, HMO, POS, etc)

List any employees not actively performing their duties full-time due to leave under FMLA, Disability or Worker's Compensation, or has a disabling illness, injury or pregnancy. Include disability, injury description, or pregnancy.

Please indicate below any employees and/or dependents who reside outside the states of Kansas, Missouri and/or Oklahoma.

**Health Information**

Please complete the following questions to the best of your knowledge. This information is necessary to evaluate your group's application. In order to protect the individuals involved, do not disclose the name of any employee or dependent. Provide the number of individuals and describe the situation.

Are you aware of any employee, dependent or COBRA or State Continuation (collectively referred to as Continuation) participants currently disabled?

Are you aware of any employee, dependent or Continuation participants who has had an organ transplant such as kidney, liver, heart or lung?

**Employer Statement**

I understand that this information may be verified by outside sources such as Equifax, or other investigative firms deemed appropriate for finalizing its approval. Coventry Health Care of Kansas, Inc. and Coventry Health and Life Insurance Company, and/or their authorized representatives (collectively referred to as "Health Plan") reserves the right to retroactively adjust the rates provided if information, including medical information, subsequently received indicates this information was incomplete, inaccurate or I have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact made in the application, and such information would have materially affected the rate calculation within a two-year period. Further, the proposal quotation may be invalidated or an enrolled group may be retroactively terminated and all premiums refunded if any material misrepresentations or omissions are found. After coverage has been in force for two years, no statement except fraudulent statements I make affect the policy.

The Company represents that the information provided on this document is complete and accurate. The Company shall notify Health Plan promptly of any changes in this information that may affect the eligibility of employees or their dependents, including the addition of any newly hired eligible employees or dependents and the termination or resignation date of any employees who are terminated by the employer. All coverage, enrollment provisions, eligibility requirements, benefits, limitations, and exclusions have been thoroughly explained to eligible employees. The Company understands that Health Plan is relying on the information provided herein and consider it material to the insurance risk assumed by Health Plan.

Renewal premiums are based on the following factors: 1) the medical inflation rate; 2) changes in coverage; 3) changes to the demographic characteristics of the group, 4) changes in the geographic area in which Company resides; and 5) the actual or expected claims costs for your group as permitted by law. Premiums are guaranteed for one year and will not be changed mid-year except for: 1) statutory changes mandating a mid-year benefit change; 2) a material change in the nature of your business or industry; or 3) any changes in benefits or enrollment criteria requested by you.

This Application is subject to final approval by Health Plan and shall be based upon all information supplied by the group, the requested benefits, and any other information obtained from outside sources deemed appropriate. This Application shall be attached to and shall become part of the Group Master Contract (the "GMC").

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.**

*underwritten by Coventry Health and Life Insurance Company and administered by Coventry Health Care of Kansas, Inc.*

Name/Title (please print)	Authorized Signature	Date
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**Agent/Broker/Producer Statement**

I certify that all the information contained in this application is correct to the best of my knowledge. I certify that the applicant is a bona-fide business establishment. I certify all participation requirements have been met. I certify that all coverage, enrollment provisions, eligibility requirements, benefits, limitations and exclusions have been carefully explained to the employer.

**Commission Split:**

Agent/Broker/Producer Name	Agent/Broker/Producer TIN	Commission Percentage
Agent/Broker/Producer Name	Agent/Broker/Producer TIN	Commission Percentage
Agent/Broker/Producer] Name	Agent/Broker/Producer TIN	Commission Percentage

Selling Agent/Broker/Producer Name (please print)

Signature

Date

Office Use Only

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	05/18/2012
<b>Comments:</b> Please see attached certification		
<b>Attachment:</b> AR Flesch Certification APP-ER-05.12.pdf		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> Application	Approved-Closed	05/18/2012
<b>Bypass Reason:</b> filing is for Application for Group Benefits included under Form Schedule tab		
<b>Comments:</b>		

	Item Status:	Status Date:
<b>Bypassed - Item:</b> PPACA Uniform Compliance Summary	Approved-Closed	05/18/2012
<b>Bypass Reason:</b> not PPACA related		
<b>Comments:</b>		

